

October 2015

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Recommended Citation

Anthony P. Merza, *Hospital Charity Care and the Corporate Campaign: Labor Union Exploitation of Dysfunctional Tax Exemption Laws*, 11 DePaul J. Health Care L. 203 (2008)
Available at: <https://via.library.depaul.edu/jhcl/vol11/iss2/5>

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HOSPITAL CHARITY CARE AND THE CORPORATE CAMPAIGN: LABOR UNION EXPLOITATION OF DYSFUNCTIONAL TAX EXEMPTION LAWS

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INTRODUCTION

As a general policy in the United States, not-for-profit hospitals receive tax exemptions from both state and federal government.¹ The assets of not-for-profit hospitals are held in the public trust and are devoted to the welfare of the general public, not private individuals.² The foregone tax revenues will therefore, in theory, benefit the public by being deployed as assets of these tax-exempt hospitals.³ By not taxing not-for-profit hospitals, those hospitals will be more likely to stay open, be more financially robust, and be more able to relieve the government of its burden delivering health services to those that are unable to pay.⁴

Recently, there has been widespread criticism of the general federal and state policy of extending tax exemption to not-for profit “charity” hospitals.⁵ Some argue that tax-exempt hospitals are not

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¹ John D. Colombo, *Hospital Property Tax Exemption in Illinois: Exploring the Policy Gaps*, 37 LOY. U. CHI. L.J. 493, 494 (2006).

² I.R.C. § 501(c)(3) (2004); See Gabriel O. Aitsebaomo, *The Nonprofit Hospital: A Call for new National Guidance Requiring Minimum Annual Charity Care to Qualify for Federal Tax Exemption*, 26 CAMPBELL L. REV. 75, 81 (2004).

³ Rev. Rul. 56-185, 1956-1 C.B. 202-203; See John D. Colombo, *The Failure of Community Benefit*, 15 HEALTH MATRIX 29, 30 (2005).

⁴ See Aitsebaomo, *supra* note 2, at 84.

⁵ Richard Haugh, *The New Union Strategy*, HOSP. & HEALTH NETWORKS MAGAZINE 32, 35 (May 2006), available at http://hnnmag.com/hnnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/PubsNewsArticle/data/2006May/0605HHN_Cover%20Story&dmain=HHNMAG.

doing enough to benefit the public to justify the foregone tax revenues.⁶ These critics argue that the public would benefit more if those revenues went into the public coffers through hospital taxation.

A major indicator of how worthy a tax-exempt hospital is of its tax exemption is the amount of charity care it provides to the general public.⁷ Critics contend that the amount of charity care is often inadequate, and is not greater in tax-exempt hospitals than it is in for-profit hospitals.⁸ The charity hospital tax exemptions, they say, should therefore be abolished. These commentators assert that the tax-exemptions for the not-for-profit hospitals should either be eliminated, or punitive measures should be taken against tax-exempt hospitals because of the inadequate amount of charity care they provide.⁹

This article will argue that this rhetoric against not-for-profit hospitals is misplaced. These hospitals are essential to providing health care to the general public, and financially damaging these already fiscally fragile hospitals would be devastatingly disruptive to health care access in this country. This paper starts by describing the nature of the not-for-profit hospital tax exemption policy and the criteria to justify tax exemption at the federal level and at the state level in Illinois. Part II of the paper offers a critique of Illinois' tax exemption policies and describes why in many cases the criteria for tax exemption are not realistic and are economically dysfunctional. Common criteria used for measuring the degree of charity care that a hospital delivers severely understate the amount of free care hospitals commonly deliver to the public. Part III will illustrate how the hospital industry—beyond just safety net hospitals—may be unable to cope with the loss of their tax exemptions, and how the social consequences of large scale hospital closures and/or cut-backs in services would be devastating and pervasive. Part IV argues that the government has regulated the hospital industry to such a degree that it has largely removed the hospital industry from the general economy, and therefore taxing hospitals at all makes little economic sense and the tax exemptions should be maintained regardless of how they are rationalized.

Finally, Part V illustrates how a large part of the criticisms heard in the media that tax-exempt hospitals are short-changing the

⁶ See Illinois Hospital Association, *The Threat to Hospital Property Tax Exemption*, <http://www.ihatoday.org/issues/payment/charity/proptaxexemp.pdf> (last visited April 30, 2007).

⁷ See Colombo, *supra* note 1, at 514.

⁸ See Illinois Hospital Association, *supra* note 6.

⁹ *Id.*

public on the amount of charity care they deliver is sponsored and fueled by labor unions. Labor unions have adopted a strategy of coercing hospitals to submit to the unionization of their work-forces by waging what are called “corporate campaigns.”¹⁰ Corporate campaigns are efforts conducted by labor unions, with the help of their political allies, to embarrass publicly hospitals by attacking hospitals through the media—with the apparent quid-pro-quo that the unions will “call off the dogs” once the hospitals submit to union demands.¹¹ Labor unions have cynically distorted the tax-exempt hospital charity care issue and have exploited those distortions in the media for use in these corporate campaigns.

The union corporate campaign strategy has been extremely successful so far. If this success continues, the delivery of charity care in this country may be the ultimate casualty, because the deleterious consequences of these destructive corporate campaigns threaten the very viability of the not-for-profit hospital system.

I. OVERVIEW OF TAX EXEMPTION LAWS

A. Hospital Exemption From Federal Income Taxation

Tax exemption is a critical hospital organizational asset. A hospital’s tax-exempt status is based on the hospital qualifying as a “charitable organization” under § 501(c)(3) of the Internal Revenue Code (I.R.C.).¹² To be a charitable organization, a hospital must have a charitable purpose.¹³ Furthermore, the hospital must provide no private benefit,¹⁴ and there must be no private inurement.¹⁵

Originally, the Internal Revenue Service (IRS) articulated the meaning of the charitable purpose requirement in Revenue Ruling 56-185.¹⁶ According to this ruling, a hospital is exempt from taxation under § 501(c)(3) if it is “operated to the extent of its financial ability for those not able to pay for the services rendered.”¹⁷

¹⁰ K. Bruce Stickler, *Avoiding the Wolf at the Door: What to do When Faced with the Threat of a Corporate Campaign*, 3 CHICAGO HOSPITAL NEWS (July 2005), <http://www.chicagohospitalnews.com/archives/default.asp?page=9&articleID=715>.

¹¹ *Id.*

¹² I.R.C. § 501(c)(3) (2004).

¹³ Treas. Reg. § 1.501(c)(3)-1(c)(1).

¹⁴ *Id.* § 1.501(c)(3)-1(d)(1)(ii).

¹⁵ *Id.* § 1.501(c)(3)-1(c)(2).

¹⁶ See Colombo, *supra* note 1, at 496.

¹⁷ Rev. Rul. 56-185. 1956-1 C.B. 202-203.

When Medicare and Medicaid were established in the 1960s, many believed that subsequent societal need for charity care would be minimal.¹⁸ Hospitals therefore feared that they would be unable to supply enough charity care to continue to qualify for the tax exemption. In response to this, the IRS developed a new standard to qualify for tax exemption, and the new standard was enunciated in Revenue Ruling 69-545.¹⁹ This new standard has been called the “community benefit standard.”²⁰

The community benefit standard articulates the notion that the promotion of healthcare for the general benefit of the community at large is in itself a charitable purpose.²¹ With this new standard, the delivery of free care to indigents was no longer a necessary factor of the “charitable purpose” requirement for tax exemption.²²

To meet the community benefit standard, the IRS supplied hospitals with several qualifying criteria.²³ A community board, for example, suggests that the hospital would be responsive to the needs of the community.²⁴ An open medical staff also suggests a commitment to the needs of the community at large rather than to a narrow constituency.²⁵ Engaging in medical research and medical training is another criterion.²⁶ Other criteria were the treatment of Medicare and Medicaid patients as well as the maintenance of an open emergency room that treated patients who could not pay.²⁷

The community benefit standard does not require charity care beyond emergency treatment, and Revenue Ruling 83-157 articulates that the maintenance of an emergency room is not even necessary if the hospital in question is a specialty hospital and emergency services are not necessary for the practice of that specialty.²⁸

¹⁸ See Colombo, *supra* note 3, at 31.

¹⁹ *Id.*

²⁰ *Id.*; See also STAFF OF JOINT COMM. ON TAXATION, *Present Law and Background Relating to the Tax-Exempt Status of Charitable Hospitals* (JCX-40-06), (September 12, 2006) available at <http://www.house.gov/jct/x-40-06.pdf>; See also *Non-Profit Hospitals' Tax-Exempt Status Under Fire from IRS, Local Governments*, JOURNAL OF THE BUS. LAW SOC'Y (October 20, 2006), http://iblsjournal.typepad.com/illinois_business_law_soc/2006/10/nonprofit_hospi.html.

²¹ Rev. Rul. 69-545, 1969-2 C.B. 117, 118.

²² *Id.*

²³ *Id.*

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.*

²⁸ Rev. Rul. 83-157, 1983-2 C.B. 94.

Beyond pursuing a charitable purpose, an exempt hospital must not allow its assets to go to the benefit of private individuals.²⁹ This “private inurement” prohibition is provided by the statutory language of § 501(c)(3) and is designed to prevent the tax-exempt hospital from transferring its assets for less than fair market value to board members, executives, influential physicians, and other “insiders.”³⁰ For example, an exempt hospital may implicate the private inurement provision by offering office space to a physician at less than fair market rent, or by purchasing property or services from a board member or executive at an inflated price.³¹

Besides the ban against “private inurement,” tax-exempt hospitals are also prohibited from serving a “private interest.”³² Under this “private interest” or “private benefits” doctrine, the tax-exempt hospital must not be involved in financial deals with private individuals—even when the transactions occur at a fair market value—if the benefits that the private individuals get as a result of the transactions are unnecessary to the promotion of the not-for-profit hospital’s charitable mission.³³ The private benefit doctrine, of course, does not apply to individuals within the charitable class.³⁴ The private benefit to individuals outside of the charitable class must only be incidental to the tax-exempt entity’s charitable mission.³⁵

This private benefit must be incidental in both a qualitative and a quantitative sense.³⁶ To be qualitatively incidental, it must be necessary for private individuals to receive the benefit in question in order for the not-for-profit hospital to be able to fulfill its charitable mission.³⁷ To be quantitatively incidental, the private benefit must be incidental in comparison to the public benefit that results from the economic interaction between the tax-exempt entity and the private entity.³⁸

²⁹ See Treas. Reg. § 1.501(c)(3)-1(c)(2).

³⁰ See Colombo, *supra* note 1, at 499.

³¹ *Id.* Bad deals of this nature are potentially allowable, however, if the negotiations between the tax exempt hospital and the private insider were done “at arms length” and are not otherwise illegal. See *Id.* at 500.

³² See Treas. Reg. § 1.501(c)(3)-1(d)(1)(ii).

³³ See Colombo, *supra* note 1, at 501.

³⁴ *Id.*

³⁵ *Id.*

³⁶ I.R.S. Gen. Couns. Mem. 39,598 (Jan. 23, 1987).

³⁷ *Id.*

³⁸ *Id.*

For example, a tax-exempt hospital may wish to create a joint venture with a group of private doctors and “spin-off” certain hospital business to the joint venture. The incentive for the hospital to do this would be the expectation that their physician partners would, as a result of the transaction, be inclined to direct more business to the joint venture facility—thereby increasing revenues to the hospital. The IRS has ruled that arrangements of this nature violate the private benefits doctrine because the financial benefit that the hospital steers to the private physicians is too substantial to be considered merely “incidental” to the hospital’s fundamental charitable mission.³⁹ The IRS opined that while arrangements of this nature may benefit the hospital financially, this benefit does not translate into a direct benefit to the community—and directly benefiting the community must be the not-for-profit hospital’s primary focus.⁴⁰ Joint ventures of this nature are only permissible if they are essential to the hospital’s charitable mission in a more direct fashion—they must be essential to establish needed and previously unavailable health care services in an underserved area.⁴¹

Furthermore, the IRS has stated that joint ventures of this nature are only permissible if the tax-exempt hospital retains operational control over the joint venture, because operational control is necessary in order for a hospital to be able to insure that the joint venture is primarily focused on providing a charitable community benefit.⁴²

B. Hospital Exemption From Illinois Property Taxation

The 1970 Illinois Constitution indicates that the Illinois General Assembly may exempt from taxation property that is used for a charitable purpose by institutions of public charity.⁴³ The Illinois Supreme Court has ruled that hospitals can qualify as charitable institutions if they deliver charity care to all in need and if they treat patients in a non-discriminatory manner.⁴⁴

The Illinois Supreme Court has not specifically ruled on the criteria that are necessary to qualify a hospital for property tax

³⁹ I.R.S. Gen. Couns. Mem. 39,862 (Nov. 22, 1991).

⁴⁰ *Id.*

⁴¹ See Colombo, *supra* note 1, at 503.

⁴² Rev. Rul. 98-15, 1998-1 C.B. 718.

⁴³ ILL. CONST. art. IX, § 6.

⁴⁴ See *Sisters of the Third Order v. Bd. of Review*, 83 N.E. 272, 273 (Ill. 1907).

exemption. There are appellate court opinions on these criteria, however, from three of the five Illinois appellate districts.

The Illinois Second District Court of Appeals in Highland Park Hospital v. Dep't of Revenue articulated six criteria to determine if a hospital is entitled to charitable status and is therefore eligible for property tax exemption.⁴⁵ The criteria were derived from Methodist Old Peoples Home v. Korzen.⁴⁶ The criteria are as follows:

1. The property in question must be used “for the benefit of an indefinite number of persons . . . for their general welfare—or in some way reducing the burdens of government;”
2. the charitable institution must have no capital, capital stock or shareholders, and earn no profits or dividends;
3. it “derives its funds mainly from public and private charity;”
4. the institution “dispenses charity to all who need and apply for it, does not provide gain or profit in a private sense to any person connected with it, and does not appear to place obstacles of any character in the way of those who need [charitable services];”
5. the institution has the burden of proving that its property actually and factually is so used; and
6. the term “exclusively used” means the primary purpose for which the property is used and not any secondary or incidental purpose.⁴⁷

In Highland Park Hospital, the Illinois Second District ruled that an Immediate Care Center owned and operated by a not-for-profit hospital did not qualify for the charity exemption.⁴⁸ All patients who received care at the center were billed, and if they could prove that they could not pay the bills, the bills were written-off as bad debt and those patients' accounts were not referred to a collection agency.⁴⁹ Bad debt

⁴⁵ *Highland Park Hosp. v. Dep't of Revenue*, 507 N.E.2d 1331 (Ill. App.Ct. 2d Dist. 1987).

⁴⁶ *Methodist Old Peoples Home v. Korzen*, 233 N.E.2d 537 (Ill. 1968); *See also* Colombo, *supra* note 1, at 507.

⁴⁷ *Methodist Old Peoples Home*, 233 N.E.2d at 541-42.

⁴⁸ *Highland Park Hosp.*, 507 N.E.2d at 1336.

⁴⁹ *Id.* at 1334.

constituted 6% of the Center's revenues.⁵⁰ Free care was not advertised.⁵¹

The court ruled that bad debt write-offs do not qualify as charity care.⁵² Charity care is care for which the institution makes no attempt to collect the bill.⁵³

Furthermore, the court stated that property can still be classified as primarily used for a charitable purpose, and hence qualify for the property tax exemption, even though the vast majority of patients pay for their care—but the institution must dispense charity to all who need it and apply for it and there must be no obstacles in the way for those who need charity care.⁵⁴ The court concluded that because the public was not informed that charity was available at the center, there was an impermissible obstacle to charity care.⁵⁵

The Illinois First District Court of Appeals also ruled that bad debt does not constitute charity care in Alivio Med. Ctr. v. Dep't of Revenue.⁵⁶ In that case, an ambulatory medical care facility wrote-off 25% of its bills as uncollectible, but still served patients with outstanding balances.⁵⁷ The court found that the facility's practice of billing all patients initially regardless of any inability to pay imposed an impermissible obstacle to charity care.⁵⁸ Also, instead of assuming that the prohibition against profits in the second factor of the Methodist Old Peoples Home test refers to private inurement, the court made the fantastic assertion that net *hospital* profits were a violation of the second factor.⁵⁹

The Illinois Appellate Court for the Third District in Riverside Med. Ctr. v. Dep't of Revenue also upheld the concept that a bad debt write-off does not constitute charity care.⁶⁰ In Riverside, a not-for-profit corporation owned a hospital and eight clinics.⁶¹ The clinics

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² *Id.* at 1336.

⁵³ *Id.*

⁵⁴ *Id.* at 1337.

⁵⁵ *Id.*

⁵⁶ *Alivio Med. Ctr. v. Dep't of Revenue*, 702 N.E.2d 189, 193 (Ill. App. Ct. 1st Dist. 1998).

⁵⁷ *Id.* at 191.

⁵⁸ *Id.* at 192.

⁵⁹ *Id.*

⁶⁰ *Riverside Med. Ctr. v. Dep't of Revenue*, 795 N.E.2d 361, 366 (Ill. App. Ct. 3d Dist. 2003).

⁶¹ *Id.* at 363.

gave care to all without demanding proof of ability to pay.⁶² The clinics would write-off debt as uncollectible after patients indicated on charity applications an inability to pay.⁶³ The clinics did not advertise the availability of charity care.⁶⁴ The corporation had net revenues of \$10 million in 1998.⁶⁵ Only 0.05% of revenues came from donations.⁶⁶

The Riverside court, in employing the Methodist Old Peoples Home criteria, stated that the presence of net revenues of \$10 million does not mandate taxation, but is not consistent with the provision of charity.⁶⁷ The paucity of donations also did not favor tax exemption.⁶⁸ Sending bills to patients before the patients demonstrate their eligibility for charity indicates that the patients received a bad debt write-off, and bad debt write-offs are not charity.⁶⁹ For service to qualify as charity care, the decision to not bill the patient must be made before care is delivered. Also, the failure to advertise the availability of charity constitutes an obstacle to those who are eligible for charity.⁷⁰

Finally, the court said that the 3% of the corporation's annual budget that was used for genuine charity care was too small a percentage, and that the discounted rates that apply to Medicare and Medicaid patients are not charity care, since they are discounts in exchange for volume.⁷¹

II. CRITICISMS OF THE ILLINOIS PROPERTY TAX EXEMPTION POLICY

Multiple aspects of the tests used in Illinois to determine eligibility for hospital property tax exemption are bad policy. This paper will now review various components of the rule for the charity care property tax exemption in Illinois and illustrate why this is the case.

⁶² *Id.*

⁶³ *Id.* at 364.

⁶⁴ *Id.*

⁶⁵ *Id.* at 363.

⁶⁶ *Id.* at 365.

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ *Id.* at 365-366.

⁷⁰ *Id.*

⁷¹ *Id.* at 367.

A. The “Private Donations” Criteria

The Illinois Appellate Court for the Third District in Riverside indicated that in order for a hospital to be tax-exempt, it must receive substantial private donations.⁷² In theory, private donations are an indication that members of the public believe in the “charitable-ness” of an organization, and that therefore the organization may be worthy of favorable tax treatment.⁷³

This rationale is weak. There may be a variety of reasons why people donate money to organizations—for status, to buy influence, to receive public recognition, etc. Large sums of money, for example, are donated to universities, museums, and political candidates—donations of this nature are not clearly motivated by the obvious charitable-ness of the beneficiary.

Also, not-for-profit hospitals receive on average less than 2% of their total revenues from private donors.⁷⁴ While this may indicate that the public does not consider hospitals to be charitable in general, the low percentage of donations may be more a reflection of the relative high level of revenues from other sources. Because private donations to hospitals are sparse in general, the presence or absence of private donations is probably not an efficient way to differentiate the degree of charitable-ness between various hospitals. Some hospitals may be more likely to receive donations from others simply because they are more famous rather than genuinely more charitable than the others. Therefore, the presence of private donations should be abandoned as a criterion for determining the charitable-ness of tax-exempt hospitals.

B. The “Exclusive Use” Criteria

The fifth and sixth factors in the Methodist Old Peoples Home test indicate that tax-exempt properties must be used exclusively for a charitable purpose.⁷⁵ If the property of a tax-exempt hospital is at times used for generating profits—by, for example, a for profit organization that is contracting with the tax-exempt hospital—the tax-exempt

⁷² *Riverside Med. Ctr.*, 795 N.E.2d at 365.

⁷³ See Colombo, *supra* note 1, at 519.

⁷⁴ See *Id.* at 520; See also LESTER M. SALAMON, AMERICA’S NONPROFIT SECTOR: A PRIMER 79 (2d ed. 1999).

⁷⁵ *Methodist Old Peoples Home*, 233 N.E.2d at 542.

hospital may lose its tax exemption.⁷⁶ This rule is sensible to an extent—there would be no reason, for example, to exempt hospital property that is used for generating profits by engaging in activities that are unrelated to the delivery of health care.

There are unresolved issues, however, regarding whether and to what extent any mere transaction between a not-for-profit hospital and a for-profit entity, in the pursuit of a health care related objective, jeopardizes the exempt status of the not-for-profit hospital. It is often necessary or desirable, in the course of delivering health care, for a tax-exempt entity to transact with for-profit organizations. In some circumstances, it may be efficacious for a tax-exempt hospital to contract with a for profit organization to deliver patient care, with the for-profit organization billing the patient separately for its services. A hospital may also wish to contract with private doctors in the course of organizing health care ventures, such as ambulatory surgery centers. According to the present rules, however, there is risk that the exemption criteria are violated if a tax-exempt hospital transacts with such for-profit organizations to deliver health care, even if the transactions with the for-profit organizations are conducted at arm's length and at fair market value.⁷⁷

Hospitals are often in a situation where it is optimal for them to contract with private entities in order to facilitate the hospital's health care mission. The exemption criteria should be liberalized to allow tax-exempt hospitals the freedom to contract more aggressively with private sector entities without risking their tax-exempt status for several reasons.

Firstly, the existing rules are vague and it is often not clear if certain ventures will run afoul of the exemption laws. For example, while it seems clear that a hospital's tax-exempt status would not be challenged because it contracted with a for-profit entity for telephone service, the exemption may be challenged if the hospital contracts with private doctors to establish an ambulatory surgery center. The rules' vagueness introduces risk to any potential transaction, and this dissuades hospitals from aggressively pursuing ventures with the private sector that would enhance health care delivery and community well-being—all in fulfillment of the hospital's health care mission.

Secondly, hospitals often seek to contract with private sector entities to facilitate the delivery of health care simply because the profit-driven competitive private sector is the most efficient mechanism

⁷⁶ *Id.*; See also Colombo, *supra* note 1, at 520.

⁷⁷ See Colombo, *supra* note 1, at 521.

for obtaining reliable high-quality service at a low cost. Contracting with the private sector for service will often actually conserve the resources of not-for-profit hospitals—resources that will be used for the community benefit—if the for-profit entities, whose profits would be taxed, can deliver certain services more cheaply and efficiently than the not-for-profit hospital can.

The concern with not-for-profit hospital contracting with for-profit entities can seem at first to be valid if the contracting is too pervasive. For example, concern may seem justified if the assets of the not-for-profit are being used merely as a platform to facilitate the business of the for-profit contractors, rather than being used for a charitable purpose.⁷⁸

This concern, however, is misguided and ideologically motivated. The for-profit organization's income is taxed, and government coffers are therefore enhanced when the for-profit takes over work that would have otherwise been done by the tax-exempt hospital. Furthermore, the tax-exempt hospital retains an essential role, as the tax-exempt hospital will tend to occupy an essential economic niche that the for-profit sector will tend to shun.⁷⁹

For example, hospitals are extremely capital intensive enterprises and their profit margins are thin in economically disadvantaged regions. The private sector will be able to find much more profitable ways of deploying assets than investing them in for-profit hospital enterprises in economically disadvantaged areas—areas that badly need hospitals.

The tax-exempt hospital serves an essential role when it serves as a platform to facilitate the activities of efficient and taxable for-profit health care delivery entities. Such symbiotic relationships that benefit society by increasing the tax base while facilitating the delivery of low-cost high-quality private sector health care services should be facilitated by government policy, not discouraged. Society benefits when the efficient low-cost and taxable private sector is allowed to assume as much of the health care delivery as they are willing—thereby allowing the not-for-profit hospitals to conserve their resources for the functions in the health care economy that the private sector is not willing to assume.⁸⁰

⁷⁸ *Id.* at 523.

⁷⁹ Of course, tax exempt hospital property should not be used as a platform for private sector profit generating activity that is not directly related to the delivery of health care.

⁸⁰ See Colombo, *supra* note 1, at 523.

Therefore, the exemption rules should be liberalized to encourage tax-exempt hospitals to establish stronger relationships with the private sector, rather than discouraging private hospitals from realizing these possible efficiencies. The government's ideological mindset of believing that private entrepreneurship should be penalized for the good of the public should be discarded and more modern understandings of economic functioning should be accommodated.

C. Measuring Charity Care

The legal criteria that are used by the courts to define charity care are vague and in some respects inappropriate. This paper will now review and critique these criteria.

i. Cost Criteria

Firstly, it is unresolved whether charity care should be measured by hospital charges, which will result in a high figure, or by hospital costs, which would result in a lower figure.⁸¹

Hospitals can set their charges arbitrarily high. An individual hospital's charges however, have limited impact on that hospital's reimbursement rates, since actual reimbursement rates are tightly controlled by the government in the case of Medicare and Medicaid, and private insurance companies have tremendous leverage in dictating actual reimbursement rates in the private market.⁸²

If a cost measure is used instead of charges, controversy exists over whether the optimal measurement is average or marginal cost.⁸³ Marginal cost is the cost of caring for an additional patient.⁸⁴ The measurement does not take into account fixed costs which represent, in part, the hospital's huge investment in infrastructure, human capital, and technology.⁸⁵ For example, a functioning hospital would have already financed an x-ray machine to service its paying customers. The marginal cost of subsequently using the machine to service the next customer, a charity case, would be low if it does not account for the

⁸¹ *Id.* at 511.

⁸² *Id.*; See also American Medical Association (AMA) Private Sector Advocacy Unit, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets* (2007), available at http://www.ama-assn.org/ama1/pub/upload/mm/368/compstudy_52006.pdf

⁸³ *Id.*

⁸⁴ See Colombo, *supra* note 1, at 512.

⁸⁵ *Id.*

cost of the already paid-for x-ray machine. Some consider this an appropriate measure of charity care because it represents the financial setback to the hospital that results from the appearance of the charity case.⁸⁶

While this may be an appropriate metric for charity care if charity cases were few, others contend that, in reality, charity cases are a continuous and permanent burden on most hospitals. As such, average costs should be used to measure charity care, since the predictable and continuous service of charity cases are contributing their share in wearing out equipment and consuming hospital resources.⁸⁷

ii. **Bad Debt**

Another contentious issue is whether bad-debt write-offs should qualify as charity care for purposes of the tax-exempt hospital charity care requirement. While the Illinois Supreme Court has not ruled specifically on this issue, all three Illinois Appellate Courts have made the unfortunate ruling that bad-debt write-offs are not charity care.⁸⁸ Courts in Illinois hold that true charity care is care for which the hospital has already determined that it will not charge for at a point in time before the care is delivered.⁸⁹ Judges consider it disingenuous for a hospital to make harsh efforts to collect debts after care is rendered and then claim the advantage of classifying the debt as charity only after rigorous attempts to collect the debt prove futile.⁹⁰

On the other hand, there is little reason to believe that a substantial portion of uncollected bad debt is a result of poor hospital collection efforts.⁹¹ For the most part, people do not pay their hospital bills because they are truly unable to pay. Uncompensated care for these patients should be classified as charity care since the patients never had an ability to pay for the care, and the hospital consumes its assets to care for them.

In order for hospitals to agree to provide uncompensated care before care is rendered—which Illinois courts require in order to

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ *See Highland Park Hosp.*, 507 N.E.2d at 1336; *See also Alivio Med. Ctr.*, 702 N.E.2d at 193; *See also Riverside Med. Ctr.*, 795 N.E.2d at 366.

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ *See Colombo, supra* note 1, at 513.

classify the care as charity care—the hospitals would have to determine the patient's financial status before delivering the care.⁹² A screening process would obviously be necessary in order for the hospital to avoid giving charity care to those who are able to pay. Hospitals would be swamped with appeals for free care if free care was given regardless of demonstrable inability to pay, because rational actors who can afford to pay for services will, in aggregate, prefer to not pay. If hospitals offer charity care routinely to large numbers of people who can afford to pay for coverage, the public would have less incentive to obtain health insurance—and the nation's health care financing would thereby be further impaired.

Scrutinizing a patient's financial records prior to delivering care is not practical because such efforts would be extraordinarily tedious, labor intensive, time consuming and would add to the already burdensome costs of serving those that are unable to pay. Moreover, medical treatment for those that are unable to pay is frequently needed on an emergent or urgent basis, and in such cases there is no time to scrutinize financial records prior to delivering care.

Hospitals are often criticized for using excessively harsh methods to collect bills from those that are unable to pay.⁹³ Hospitals, however, must make vigorous efforts to collect fees after care is rendered. If hospitals did not make vigorous collection efforts, there would be less incentive for the general public to maintain health insurance. This would increase the number of uninsured, and would increase costs on those who have health insurance who must subsidize those who do not have health insurance with higher and higher premiums.

Not allowing hospitals to classify bad debt as charity care leads to a tremendous under-estimate of the amount of free uncompensated care that hospitals render to the uninsured and indigent population. According to a 2006 study by the Center for Tax and Budget Accountability, a total of twenty-one Chicago area not-for-profit hospitals together provided over \$105 million in charity care in 2004.⁹⁴

⁹² *Id.*

⁹³ K. Bruce Stickler, *Health Care Providers, it is Time to Tell Our Story: The Silver Lining Among Dark Clouds*, 2 CHICAGO HOSP. NEWS (January 2005), available at <http://www.chicagohospitalnews.com/archives/default.asp?page=12&articleID=557>.

⁹⁴ See CENTER FOR TAX AND BUDGET ACCOUNTABILITY, AN ANALYSIS OF THE TAX EXEMPTIONS GRANTED TO COOK COUNTY NON-PROFIT HOSPITALS AND THE CHARITY CARE PROVIDED IN RETURN 16 (May 2006), available at http://www.ctbaonline.org/All%20Links%20to%20Press%20and%20Reports/Home%20Page/Charity%20Care%20Study_Final%20Released.pdf.

The care was measured based on the costs of providing the care.⁹⁵ Bad debt expenses for these hospitals, however, totaled over \$181 million.⁹⁶ Some investigators have assumed that at least half of the amount of bad debt represents the cost of providing care to the indigent and is not a result of debt avoidance and/or poor hospital debt collection efforts.⁹⁷ Despite making this assumption, it is still clear that tax-exempt hospitals in Illinois are providing nearly twice the amount of charity care to the poor that Illinois courts will credit them.

iii. Defining the Amount and Type of Charity Care Required

The Illinois Appellate Court for the Third District in Riverside opined that 3% of gross revenues dedicated to charity care—as defined as charity care excluding bad debt—is too low to justify tax exemption.⁹⁸ The court voiced concern that the majority of the care given at a clinic was not charity care.⁹⁹ No Illinois court, however, has defined precisely how much charity care is enough.¹⁰⁰

One may argue that tax-exempt hospitals should be required to provide more charity care than for-profit hospitals commonly do in order for their tax exemptions to be justified.¹⁰¹ Some contend that the value of the charity care should be equal to the foregone taxation.¹⁰²

Alternatively, one may argue that for-profit hospitals are required to provide charity service that firms in other industries in the private sector are not required to provide because of the EMTALA laws.¹⁰³ Therefore it is not fair to require tax-exempt hospitals to provide so much more charity care than the already artificially high level that for-profit hospitals are required to provide.

iv. The Community Benefits that are Not Considered

In contemplating the degree of charity care that should be required, one should keep in mind that tax-exempt hospitals provide community benefits above and beyond the charity care that Illinois

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ *Id.* at 10.

⁹⁸ See *Riverside Med. Ctr.*, 795 N.E.2d at 367.

⁹⁹ *Id.*

¹⁰⁰ See Colombo, *supra* note 1, at 514.

¹⁰¹ *Id.*

¹⁰² *Id.* at 515.

¹⁰³ 42 U.S.C. § 1395dd.

courts will recognize. Besides the judicially recognized charity care—as defined as the cost of providing free care when the decision to provide the free care is made before treatment is begun—tax-exempt hospitals also provide myriad other benefits.¹⁰⁴ Some of these benefits are quantifiable and others, while more intangible, are real nonetheless. These substantial benefits, which will be threatened if critics are successful in stripping hospitals of their tax-exempt status, will now be considered in detail.

The Medicare and Medicaid programs, for example, are a huge burden on the federal government and on American taxpayers. Hospitals subsidize these systems to a tremendous degree. On average, Medicaid reimburses hospitals only 73 cents for every dollar of hospital cost, and Medicare reimburses hospitals on average only 92 cents for every dollar of hospital cost.¹⁰⁵ The Illinois Hospital Association estimates that in 2004 Illinois hospitals subsidized \$1.686 billion in shortfalls from government sponsored health care programs.¹⁰⁶

Bad debt expense, as discussed earlier, is not considered to be charity care by the courts because the patient is billed.¹⁰⁷ Bad debt expense was estimated to total \$1.130 billion for Illinois hospitals in 2004.¹⁰⁸ Actual charity care—care for which a decision was made not to bill the patient before the patient was treated—at cost for that year was \$250 million.¹⁰⁹

In 2004, Illinois hospitals provided \$215 million in subsidized health services—free services such as poison control, sick child's day

¹⁰⁴ ILLINOIS HOSPITAL ASSOCIATION, ILLINOIS HOSPITALS HELPING THEIR COMMUNITIES: IT'S ABOUT MORE THAN JUST THE NUMBERS 7, *available at* <http://www.ihatoday.org/issues/payment/charity/ilhospcomm.pdf>; *See also* HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION, P&P BOARD EXAMINES THE RELATIONSHIP OF COMMUNITY BENEFIT TO HOSPITAL TAX-EXEMPT STATUS (April 20, 2005), *available at* http://www.hfma.org/publications/know_newsletter/archives/042005.htm; *See also* HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION, COMMENTS ON MAY 2005 HEARING, "A REVIEW OF THE TAX-EXEMPT HOSPITAL SECTOR" (June 3, 2005) *available at* http://www.hfma.org/library/compliance/taxexempt/400457_tax_exempt_attributes.htm.

¹⁰⁵ METROPOLITAN CHICAGO HEALTHCARE COUNCIL AND ILLINOIS HOSPITAL ASSOCIATION, CARING FOR THEIR COMMUNITIES: A COMPREHENSIVE REPORT ON THE COMMUNITY BENEFITS PROVIDED BY TAX-EXEMPT HOSPITALS IN COOK COUNTY 5 (May 2006), *available at* http://www.ihatoday.org/issues/payment/charity/benefits_report.pdf.

¹⁰⁶ *See* ILLINOIS HOSPITAL ASSOCIATION, *supra* note 104, at 4.

¹⁰⁷ *See Highland Park Hosp.*, 507 N.E.2d at 1336; *See also Alivio Med. Ctr.*, 702 N.E.2d at 193; *See also Riverside Med. Ctr.*, 795 N.E.2d at 366.

¹⁰⁸ *See* ILLINOIS HOSPITAL ASSOCIATION, *supra* note 104, at 4.

¹⁰⁹ *Id.*

care, literacy training, job training, Halloween candy screening, special programs for AIDS patients, child and maternal health care, special programs for the elderly and disabled, etc.¹¹⁰ In that same year Illinois hospitals contributed \$261 million for medical education—the training of future doctors, nurses and other health care professionals.¹¹¹ Another \$36 million was contributed for medical research and \$10 million was contributed for language assistance.¹¹² Overall, the Illinois Hospital Association estimates that in 2004 Illinois hospitals provided a total of \$3.679 billion in community benefits of subsidized health services.¹¹³

Furthermore, tax-exempt hospitals by their nature serve as a platform for other benefits that the community derives that cannot be readily delivered through other venues. If hospitals lose their tax-exempt status, for example, they may gain incentive to become for-profit in order to raise money through the private financial markets and through private investors.¹¹⁴

Under these conditions, hospitals would be incentivized to downgrade or even eliminate services for which hospitals almost invariably lose money, but which are vital to the community nonetheless—services such as trauma care, neonatal intensive care, burn units, AIDS clinics, community immunization programs, ambulance services, etc.

Government is ill-equipped to benefit the public from tax revenues to the same degree that hospitals are positioned to benefit the public when tax-exempt hospitals are allowed to retain those revenues in the form of tax exemptions. Hospitals have expertise in delivering health care and hospitals have the mechanisms in place for delivering health care efficiently—the government does not. Consider how the government would manage to develop and deploy new medical innovations and equipment, recruit, train and retain health care professionals, deliver health care services in a high quality manner at the point where the services are most needed, etc. Government, by its very nature, simply does not have the efficiency or expertise to deliver these benefits to society in a cost effective manner.

¹¹⁰ *Id.*

¹¹¹ *Id.*

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ CONGRESS OF THE UNITED STATES CONGRESSIONAL BUDGET OFFICE, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS 6 (December 2006), available at <http://www.cbo.gov/ftpdocs/76xx/doc7695/12-06-Nonprofit.pdf>.

D. Tax-Exempt Hospitals and “Profits”

The Illinois First District Court of Appeals in *Alivio* actually ruled that tax-exempt hospitals may not make profits.¹¹⁵ This shocking ruling betrays a misunderstanding of the meaning of “not-for-profit” status. Charitable status means that a certain type of organization is tax-exempt because it devotes its resources for certain charitable purposes instead of private benefit—it does not mean the organization does not make profits.¹¹⁶ No organization can stay alive unless it makes profits. If an organization is consistently losing money—by having revenues consistently less than expenditures—eventually there will be inadequate resources available to pay the necessary expenses to keep the enterprise functioning.¹¹⁷ The real issue concerns the tax-exempt hospital’s proper use of its profits, not the existence of profits. Hoarding profits may eventually become an issue with respect to those not-for-profit hospitals that are fortunate enough to be located in economically advantaged regions. In those cases, tax exemption policy considerations should be directed at the proper use of those accumulated profits—not the mere existence of those accumulated profits.¹¹⁸

III. THE CONSEQUENCES OF REVOKING THE HOSPITAL TAX EXEMPTIONS

A. Hospital Ability to Survive Taxation

Hospitals can benefit from variety of different types of federal and state tax exemptions.¹¹⁹ The Congressional Budget Office in a December 2006 report estimated that the total value of tax exemptions for not-for-profit hospitals in the United States was valued at \$12.6 billion in 2002.¹²⁰ Approximately half the value of the tax exemption was estimated to be federal and half was state and local.¹²¹

¹¹⁵ See *Alivio Med. Ctr.*, 702 N.E.2d at 192.

¹¹⁶ See Colombo, *supra* note 1, at 517.

¹¹⁷ *Id.*

¹¹⁸ *Id.* at 518.

¹¹⁹ See CENTER FOR TAX AND BUDGET ACCOUNTABILITY, *supra* note 94, at 7.

¹²⁰ See CONGRESS OF THE UNITED STATES CONGRESSIONAL BUDGET OFFICE, *supra* note 114, at 3.

¹²¹ *Id.*

Across the nation, many hold the opinion that not-for-profit hospitals are not doing enough charity care to justify their tax exemptions, and that their tax-exemptions should be revoked.¹²² The issue then becomes the consequences of revoking the tax exemptions. Would substantial numbers of tax-exempt hospitals still have the resources to deliver quality medical care if their tax exemptions were denied? Would substantial numbers of such hospitals even stay open? What would be the impact on the delivery of health care if the current charity care laws were strictly enforced across the board and tax-exempt hospitals were taxed when judged to be providing inadequate levels of charity care?

The first step in answering these questions is to estimate the amount of money various hospitals are excused from paying in taxes each year because of their exempt status. Next, a comparison should be made between the profitability of these hospitals and the amount of tax they are excused from paying. Through this comparison, an impression can be gained regarding the ability of various hospitals to service their respective tax burdens in the event that their tax-exempt status was revoked. It is not possible to arrive precisely at these numbers for a variety of reasons.

Property values, for example, are needed to determine accurately the relevant property tax bills.¹²³ In Cook County Illinois, however, the Cook County Assessor's Office does not assess property values for tax-exempt organizations.¹²⁴ The Assessor's Office values commercial taxable property based on either the income of the entity to be taxed or a combination of the income and the replacement costs of the property.¹²⁵ Tax-exempt hospital profitability data is generally accessible through the publicly available Federal Form 990 that each federal income tax-exempt organization is required to file.¹²⁶ Data regarding the replacement costs of hospital property is generally not available.¹²⁷ If the income of the commercial entity is negative—the entity is operating at a net loss for the year—the Assessor's Office will, nonetheless, use the replacement cost method to assess property taxes for that year.¹²⁸

¹²² See Aitsebaomo, *supra* note 2, at 92.

¹²³ See CENTER FOR TAX AND BUDGET ACCOUNTABILITY, *supra* note 94, at 14.

¹²⁴ *Id.* at 13.

¹²⁵ *Id.* at 14.

¹²⁶ Available at <http://www.guidestar.org>.

¹²⁷ See CENTER FOR TAX AND BUDGET ACCOUNTABILITY, *supra* note 94, at 14.

¹²⁸ *Id.*

Moreover, any attempt to determine if tax-exempt hospitals would be able to sustain tax expenses in the event that their tax exemption would be revoked is hampered by the fact that it is unpredictable how a tax-exempt hospital would respond to the loss of its exempt status.¹²⁹ A hospital, for example, may respond to a removal of its tax-exempt status by becoming for-profit and by changing its service offerings.¹³⁰ A hospital in such a position may also dramatically change its capital structure, its physical assets, its cost structure, its accounting practices, etc.¹³¹ Changes of this nature could have a dramatic effect on the hospital's profitability and the subsequent tax bill.¹³² Predicting such changes with any precision is probably impossible.

With these and other constraints in mind, the Center for Tax and Budget Accountability embarked on an ambitious project to estimate the value of the tax exemptions enjoyed by some not-for-profit hospitals in Cook County Illinois for the year 2004.¹³³ They estimated the sum of federal income taxes added to state and local taxes that certain Cook County not-for-profit hospitals would have had to pay for fiscal year 2004 in the event that they were not tax-exempt.¹³⁴ They eliminated from their study Cook County not-for-profit hospitals for which relevant data was not available.¹³⁵

Below is a listing of these values for each hospital set against each respective hospital's net income as reported on line 18 of the hospital's Federal Form 990 filing for the fiscal year 2004. The comparison is made in an effort to grossly estimate the degree to which these hospitals would have been able to accommodate their respective tax bills in the event that the federal and state governments had revoked their tax-exempt status. Results are as follows:

¹²⁹ See CONGRESS OF THE UNITED STATES CONGRESSIONAL BUDGET OFFICE, *supra* note 114, at 6.

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² *Id.*

¹³³ See CENTER FOR TAX AND BUDGET ACCOUNTABILITY, *supra* note 94, at 10.

¹³⁴ *Id.*

¹³⁵ *Id.* at 11.

COMPARISON OF NOT-FOR-PROFIT HOSPITAL TAX EXEMPTIONS vs. INCOME NET EXPENSES (FY 2004)			
HOSPITAL	INCOME NET OF EXPENSES¹³⁶	VALUE OF ALL TAX EXEMPTIONS¹³⁷	TAX EXEMPTIONS AS PERCENTAGE OF INCOME
Advocate Health Care Network	\$120,107,807	\$79,032,570	65.80%
Alexian Brothers Hospital Network	\$44,675,577	\$25,186,811	56.38%
Evanston Northwestern Healthcare	\$42,781,556	\$22,980,617	53.72%
Gottlieb Memorial Hospital	\$4,538,691	\$4,289,045	94.50%
Holy Cross Hospital	(\$2,464,585)	\$4,018,838	-163.06%
Jackson Park Hospital	\$2,670,894	\$1,188,516	44.50%
Little Company of Mary Hospital	\$23,876,880	\$11,034,567	46.21%
Loyola University Medical Center	\$15,183,875	\$20,297,147	133.68%
Mercy Hospital and Medical Center	\$3,231,397	\$3,781,966	117.04%
Mount Sinai	(\$8,149,339)	\$2,852,605	-35.00%
Palos Community Hospital	\$21,695,440	\$7,792,176	35.92%
Resurrection Health Care	\$16,264,525	\$44,858,697	275.81%
Roseland Community Hospital	(\$2,560,114)	\$528,846	-20.66%
Rush North Shore Medical Center	(\$580,473)	\$5,533,584	-953.29%
Rush University Medical Center	\$101,042,277	\$22,425,246	22.19%
and Rush Oak Park			
Saint Anthony Hospital	(\$3,240,435)	\$5,444,798	-168.03%
St. Bernard Hospital	\$2,888,622	\$1,740,025	60.24%
South Shore	(\$796,428)	\$857,923	-107.72%

¹³⁶ Income net of expenses as indicated on line 18 of 2004 Federal Form 990. See *supra* note 126.

¹³⁷ See CENTER FOR TAX AND BUDGET ACCOUNTABILITY, *supra* note 94, at 20.

Hospital			
Thorek Hospital	\$14,007,724	\$4,538,387	32.40%
University of Chicago Hospitals	\$103,642,743	\$42,782,111	41.28%

Several observations can be made from the above data. The values of the tax exemptions are a very significant percentage of even the wealthiest hospital's net income. High income health care organizations such as Advocate Health Care Network, Rush University Medical Center and Rush Oak Park, and the University of Chicago Hospitals would still seem to have healthy profit margins even if their tax exemptions were revoked. We should be cautious in this conclusion, however, because these are very innovative health systems that offer services that smaller community hospitals cannot afford. Obtaining new and innovative technology is financially risky because hospitals cannot predict with certainty if new technology will prove clinically efficacious and to what degree it will be used. We cannot judge the degree to which the leading hospitals' appetites for innovation will be curtailed if their profit margins are significantly trimmed. Indeed, it seems that even Loyola University Medical Center, a leading academic center, would be pushed into the red if its tax exemption was revoked.

Alexian Brothers Hospital Network, Evanston Northwestern Healthcare, and Palos Community Hospital are wealthy community hospitals in affluent suburban neighborhoods. The loss of their tax exemptions would seem to take up 56-35% of their net incomes, but their profit margins would still be much higher than the majority of the hospitals in the survey. These, however, are also innovative and well-stocked hospitals, and less affluent hospitals refer cases to them when the less affluent hospitals lack the necessary resources for difficult cases. We cannot predict the health care delivery consequences and the social costs of trimming their profit margins.

Finally, for the majority of hospitals in this survey, the loss of their tax exemptions would be absolutely devastating. For these hospitals, the loss of the tax exemptions would either substantially eliminate their profit margins or leave them with slight profit margins because their revenues are already modest. Not all of these hospitals are even in poor neighborhoods. Rush North Shore Medical Center, in the affluent north suburbs of Chicago, is already \$580,473 in the red despite its \$5,533,584 tax exemption. Hospitals that serve in poor neighborhoods, such as Roseland Community Hospital, Saint Anthony

Hospital, and South Shore Hospital would apparently be substantially wiped out. Even Resurrection Health Care, a very large hospital chain that serves affluent areas as well as poorer areas—and subsidizes health care delivery in poorer areas with income from affluent areas—would apparently have its \$16,264,525 profit margin wiped out and then some if it lost its \$44,858,697 tax exemption.

Thus, while it seems logical to argue that if hospitals are not doing “enough” charity care their tax exemptions should be revoked, it is not easy to find a socially painless manner to extract this justice. The survey of the above hospitals suggests that the loss of their tax exemptions, regardless of how justified, would almost certainly cause tremendous dislocations in health care delivery in poor neighborhoods, and may even cause serious health care access issues in many affluent areas.

B. The Consequences of the Overall Financial Fragility of the Hospital Industry

If efforts to deprive hospitals of their tax-exempt status are successful, there will be other societal consequences that are even more devastating and far reaching—largely because of the probable inability of most hospitals to financially cope with a loss of their tax-exempt status. The Illinois Hospital Association currently estimates that 36% of the hospitals in the state of Illinois are functioning with negative operating margins.¹³⁸ Furthermore, 63% of hospitals in Illinois are operating with negative patient margins—they are losing money on their core function, providing direct service to patients.¹³⁹ The average overall operating margin for Illinois hospitals is a razor thin 1.6%.¹⁴⁰ The margin for direct patient care services is -3.7%.¹⁴¹ Indeed, 23 hospitals have closed in the state of Illinois since 1994.¹⁴²

If tax-exempt hospitals lose their exemptions, the already fragile hospital industry may very well suffer major devastation. The cost to society would be difficult to contemplate. For-profit hospitals would be burdened with increasing numbers of the uninsured—and for-profit

¹³⁸ See ILLINOIS HOSPITAL ASSOCIATION, *supra* note 104, at 5.

¹³⁹ *Id.*

¹⁴⁰ *Id.* The operating margin is the difference of revenues over expenses as a percentage of total expenses. Investment and other non-patient care income and expenses are not included in this measure.

¹⁴¹ *Id.*

¹⁴² *Id.*

hospital viability would become more tenuous. Approximately 14.3% of the Illinois population is without health insurance.¹⁴³ Illinois hospitals provided \$1.2 billion in un-reimbursed services in 2004.¹⁴⁴ Major hospital cut-backs and closings that may result from hospitals losing their tax-exempt status would cause major dislocations in access to health care, especially for the most vulnerable populations.

Then there is the cost to the private non-health care sector that would result from hospital cut-backs and closings. In 2003, Illinois community hospitals employed 233,500 people with total annual wages and benefits of over \$10.7 billion.¹⁴⁵ Hospitals are among the top three employers in 47% of Illinois counties.¹⁴⁶ The economic costs that would result from the loss of any significant percentage of these jobs—not to mention the lost income tax revenues consequent to the loss of these jobs—should give pause to those who argue that the lost tax revenues due to hospital tax exemptions are excessively costly to society.

IV. THE ECONOMIC RATIONALE OF TAXING THE HOSPITAL INDUSTRY

Taxing hospitals in the same manner as any firm in the general economy is taxed makes little economic sense. The hospital industry in this country is heavily regulated, and hospitals do not function as participants in a market economy in the same sense that firms operate in less controlled sectors of the economy. For example, a U.S. Census Bureau study found that in U.S. hospitals, Medicare provides 40% and Medicaid provides 13% of patient revenues.¹⁴⁷ These reimbursement rates are set by the government and are not the result of free market

¹⁴³ *Id.* at 7.

¹⁴⁴ *Id.*

¹⁴⁵ See ILLINOIS HOSPITAL ASSOCIATION, ILLINOIS HOSPITALS AT A GLANCE, available at <http://www.ihatoday.org/about/hospitals/ilhosp.html>. A recent study projects that hospital employment will generate over 50,000 new jobs in the Chicago Metropolitan Area alone between 2004 and 2020. The study recommended policies to further encourage hospital job growth; See METROPOLITAN CHICAGO HEALTHCARE COUNCIL, THE ECONOMIC IMPACT OF CHICAGO'S HOSPITALS ON THE METROPOLITAN CHICAGO AREA 30, available at http://www.mchc.org/care/economic_report.pdf.

¹⁴⁶ See ILLINOIS HOSPITAL ASSOCIATION, *supra* note 104, at 7.

¹⁴⁷ Patricia Buscher, *Hospital, Physician and Other Health and Social Assistance Revenues Reach \$1.2 Trillion in 2002*, U.S. CENSUS BUREAU NEWS (December 16, 2003), available at http://www.census.gov/Press-Release/www/releases/archives/service_industries/001620.html#figureB.

negotiations. Furthermore, government policies are engineered to support the formation and market viability of managed care organizations—and the managed care organizations are consequently positioned to drive hard bargains with hospitals. Moreover, all acute care hospitals, whether tax-exempt or for-profit, are legally obliged to provide emergency services to those who are unable to pay—a result of EMTALA and other laws—a burden unlike any faced by firms in most other sectors of the private economy.¹⁴⁸ Also, tax-exempt hospitals have no private equity holders with incentives to squeeze profits for personal gain at the expense of the community.

As this paper demonstrated above, if tax-exempt hospitals lose their exemptions, the economic viability of a substantial proportion of them will be in jeopardy. This would place the for-profit hospital sector at risk as well, because care for the uninsured will be shifted to those hospitals. The entire hospital industry would therefore be jeopardized by the loss of hospital tax exemptions.

With these factors in mind, it seems that taxing entities that are so highly regulated and that have no clear individual profit incentive—as if they were like any free-wheeling profiteering firms in the market economy—is a concept that is artificial, disingenuous, and in this case dangerous. The government has chosen to regulate the hospital industry to such a significant degree that it has, to a considerable extent and as a practical matter, largely taken ownership of the hospital industry. The government must therefore design rules to keep the hospital industry afloat. The hospital tax exemptions go a long way to keep hospitals functioning despite the tremendous constraints and burdens imposed on hospitals by the government.

The issue of whether the tax-exempt hospitals are “entitled” to their tax exemptions according to various ill-conceived parameters that the legislatures or the courts may entertain is missing a larger point. If the tax-exempt hospitals are not entitled to their tax exemptions according to the rules, then we simply need a new set of rules. Society simply cannot afford to allow hospitals to suffer any further financial impairment—the social consequences would be devastating. Further, because the government largely engineered the current hospital economy, it’s up to the government to ensure that the hospital economy keeps functioning. The hospital tax exemptions for all practical purposes simply must remain in place, regardless of how they are justified.

¹⁴⁸ 42 U.S.C. § 1395dd.

V. ORGANIZED LABOR'S ASSAULT ON TAX-EXEMPT HOSPITALS—EXPLOITATION OF THE CHARITY CARE ISSUE

The issue of whether tax-exempt hospitals deserve their tax exemptions has received increasing attention in the news media in recent years.¹⁴⁹ Politicians and special interest groups have also directed more attention to this issue.¹⁵⁰ Many hospitals and hospital chains have been the focus of intense media scrutiny because of public accusations that they provide inadequate levels of charity care to justify their tax exemptions.¹⁵¹

The public focus on the tax-exempt hospital charity care issue has to a large degree been inspired, initiated and promoted by labor unions.¹⁵² Labor unions use the charity care issue, along with a variety of other issues, to harass and publicly embarrass hospitals in order to coerce hospitals to accept terms that facilitate the unionization of the hospital's work force.¹⁵³ Unions use their allies in the news media, in government, and among special interest groups to assist in these public assaults.¹⁵⁴ These well-researched, well-financed, and highly organized public assaults are termed "corporate campaigns," and they can last years until a hospital eventually capitulates.¹⁵⁵ If a target hospital capitulates to union demands and the hospital's work force is unionized, there is the tacit understanding that the corporate campaign will cease—notwithstanding, of course, whether or not the set of initial union "concerns" were redressed.¹⁵⁶

This innovative union strategy of cynically exploiting issues such as charity care, patient safety, etc. to promote public corporate campaigns against target hospitals has met with extraordinary success across the country.¹⁵⁷ As these labor union assaults on hospitals become more pervasive and sophisticated, the financial health and, indeed the very viability of many hospitals may be threatened. The damage done to hospitals by these corporate campaigns is significant,

¹⁴⁹ See Stickler, *supra* note 93.

¹⁵⁰ *Id.*

¹⁵¹ *Id.*

¹⁵² *Id.*

¹⁵³ See Haugh, *supra* note 5.

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

and the increased operating costs and administrative inefficiency inherent with a unionized workforce will threaten the viability of many financially borderline hospitals. The deleterious consequences to quality of patient care and access to health care cannot be understated.

This paper will now describe some details of the process of work force unionization, and then will describe the history and the evolution of labor union corporate campaigns. This paper will then describe how corporate campaigns are implemented, how they have been conducted against hospitals across the country by cynically exploiting the charity care issue, and why they may lead, if unchecked, to further destabilization of our already over-stressed health care system.

A. The Process of Workforce Unionization

In the classic process by which a labor union unionizes a workforce, the union endeavors to convince employees to sign "authorization cards" which authorize the union to represent the employee.¹⁵⁸ When the union obtains such signatures from at least 30% of the target firm's work force, the union presents the signatures to the National Labor Relations Board (NLRB) and files a "petition for an election."¹⁵⁹

After approval of the petition, a meeting of the entire work force is held during which the employees vote on whether or not to agree to allow the union to represent them.¹⁶⁰ The elections are supervised by officials of the NLRB who are in attendance, the ballot is secret, and the results are counted and announced by NLRB officials immediately.¹⁶¹

In exchange for representing workers against management, the union typically receives 2 ½ to 3 times the employee's hourly pay rate each month in union dues.

This process is difficult for the unions.¹⁶² The unions commonly fail in this process because the ballots are secret, and

¹⁵⁸ See National Labor Relations Act, 29 U.S.C. §§ 151-169, available at http://www.nlr.gov/about_us/overview/national_labor_relations_act.aspx; See also NATIONAL LABOR RELATIONS BOARD, PROCEDURES GUIDE, http://www.nlr.gov/publications/procedures_guide.htm.

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

¹⁶¹ *Id.*

¹⁶² Jarol B. Manheim, TRENDS IN UNION CORPORATE CAMPAIGNS: A BRIEFING BOOK 22 (2005), available at <http://www.uschamber.com/NR/rdonlyres/eizjeua6jb3cwx74d>

therefore the workers cannot be coerced during the actual election.¹⁶³ Also, management is free to attempt to dissuade workers from agreeing to union representation.¹⁶⁴

As a strategic alternative to this process, modern unions often resort to the corporate campaign.¹⁶⁵ The purpose of the corporate campaign is to pressure management into agreeing to dispense with the above process and instead agree to neutrality, card check, and master agreements—all of which offer much greater odds for union success.¹⁶⁶

Neutrality is a promise by management that it will not endeavor to dissuade its employees from voting for the union.¹⁶⁷ This is an important factor, because management is consequently deprived of the benefit of lawyers and other consultants who have expertise in ways to defeat union organizing campaigns.¹⁶⁸

Card check is a process, allowed by law, by which management agrees that if the union can get greater than 50% of the employees to sign an agreement accepting union representation, management will voluntarily submit to the unionization of its work force without an employee election.¹⁶⁹ In this process, instead of the government supervised secret ballot election during which workers cannot be coerced, the election is dispensed with and the union is allowed to confront workers individually to convince them to sign the agreement to union representation.¹⁷⁰ The union, in this process, is allowed to confront workers in their homes and under a variety of circumstances that are not allowed under a NLRB-conducted procedure.¹⁷¹

Master Agreements are agreements between unions and management in which a single overarching agreement is achieved rather than multiple smaller negotiations and agreements that individually cover only a limited segment of the firm's work force.¹⁷² Master agreement are advantageous to unions because they increase

rip643bsjc2btgf7e6tc4h57cbg2x6gxtjz5hcruutpwtwtlssdyv4mkfi6laa2kmqc7h2ab3f/
Union_booklet_FINAL_small.pdf.

¹⁶³ *Id.* at 23.

¹⁶⁴ *Id.*

¹⁶⁵ Jarol B. Manheim, *THE DEATH OF A THOUSAND CUTS: CORPORATE CAMPAIGNS AND THE ATTACK ON THE CORPORATION* 38 (2001).

¹⁶⁶ *Id.*; *See also* Manheim, *supra* note 162, at 23.

¹⁶⁷ Manheim, *supra* note 165, at 38.

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

¹⁷⁰ *Id.* at 38-39

¹⁷¹ *Id.* at 39

¹⁷² *Id.*

union leverage—expiration of the agreement will involve a larger segments of the firm's work force and place the firm in greater jeopardy.¹⁷³

Neutrality, card check, and master agreements are extremely advantageous to unions because they greatly simplify the union's organizing efforts and they greatly increase the odds that the union will successfully organize the target company's work force.¹⁷⁴ The purpose of the corporate campaign, then, is to coerce management into agreeing to neutrality, card check and master agreements.¹⁷⁵ This paper will now focus on the history and nature of the corporate campaign.

B. The Origins of the Corporate Campaign

Corporate campaigns did not start in the labor movement.¹⁷⁶ The concept of the corporate campaign originated at the University of Michigan around 1965—the brain child of the local chapter of the radical Students for a Democratic Society (SDS).¹⁷⁷ While some elements of the SDS morphed into the Vietnam War era “Weathermen” and the bomb-detonating “Weather Underground,” the SDS also had a more cerebral component.¹⁷⁸ The SDS saw the corporation as being the critical entity that defines and maintains the social class structure in American society.¹⁷⁹ Thus the SDS surmised that the corporation should be the principle target of attack in order to achieve its goal of radical social change.¹⁸⁰ Furthermore, the SDS adopted the strategy of allying itself with labor unions, left-wing religious organizations such as the National Council of Churches, and other left-wing social activist groups of various sorts because through these other entities, the SDS's efforts to achieve their agenda acquired an air of legitimacy.¹⁸¹

These New Left coalitions began their assaults on corporations by conducting thorough research on the

¹⁷³ *Id.*; See also *Under the Knife: Are Union Bosses Causing Healthcare Costs to Skyrocket?*, LIBERTY WATCH MAGAZINE (April 2006), available at <http://www.liberty-watch.com/volume02/issue01/coverstory.php>.

¹⁷⁴ See Manheim, *supra* note 165, at 39.

¹⁷⁵ *Id.*

¹⁷⁶ *Id.* at 2.

¹⁷⁷ *Id.* at 3.

¹⁷⁸ *Id.* at 4.

¹⁷⁹ *Id.* at 5.

¹⁸⁰ *Id.*

¹⁸¹ *Id.* at 6.

potential weak points of their targets.¹⁸² As one of their early policy manuals reiterated: Knowledge of such points gives us the leverage to challenge the system effectively with the means at our disposal. Sometimes even an apparently insignificant weakness can be effectively exploited. The public image of a corporation, for instance, can be important to its continued prosperity—investment, government contracts, employee recruiting, etc., can all be affected by a change in this image.¹⁸³

Gathering such information, in other words, is essential to uncover pressure points that can be used to attack and undermine the target corporation.

The SDS, thoroughly infiltrated by rabid Marxists, eventually disintegrated.¹⁸⁴ But many of their distinguished alumni and disciples went on to grace faculties of universities, serve on legislatures, preside over the courts, man news media outlets, and infiltrate at least one major political party.¹⁸⁵ Others became cherished consultants of the labor movement.¹⁸⁶

Saul Alinsky later refined the nascent tactics of the corporate campaign. Saul Alinsky was trained at the venerable University of Chicago, and he was the preeminent radical community organizer of the 1930s.¹⁸⁷ By the 1960's and 1970's he was instrumental in assisting community activists in efforts to extract hiring concessions from prominent corporations, such as Eastman Kodak.¹⁸⁸ In this vein,

¹⁸² *Id.*

¹⁸³ *Id.* at 7; See also NORTH AMERICAN CONGRESS ON LATIN AMERICA, NACLA RESEARCH METHODOLOGY GUIDE 2 (New York 1970).

¹⁸⁴ See Manheim, *supra* note 165, at 9.

¹⁸⁵ *Id.* Tom Hayden, for example, entered electoral politics. Bob Ross and Heather Booth served on the staffs of the Democratic National Committee and Democratic office holders. Michael Lerner became a publisher. Richard Flacks, Todd Gitlin and Bob Ross became university professors. Bernardine Dohrn, who was part of the leadership of the Weather Underground and who was on the FBI's Ten Most Wanted list, teaches law today at Northwestern University — her husband, Bill Ayers, himself a former central figure in the Weathermen, is currently a professor of education at the University of Illinois at Chicago. See *The Weather Underground: The Weathermen Today*, PBS available at <http://www.pbs.org/independentlens/weatherunderground/today.html>.

¹⁸⁶ *Id.* Paul Booth, Michael Ansara, Michael Locker, Ira Arlook, Heather Booth, and Steve Max became active in the labor movement.

¹⁸⁷ See Manheim, *supra* note 165, at 11.

¹⁸⁸ *Id.* at 12.

he wrote his “Rules for Radicals” which contain tactics which today are commonly employed by labor unions in their corporate campaigns.¹⁸⁹ A sample selection is as follows:

1. Power is not only what you have, but what the enemy thinks you have.
2. Never go outside the experience of your people.
3. Whenever possible, go outside the experience of your enemy.
4. Make the enemy live up to their own book of rules.
5. Ridicule is man’s most potent weapon.
6. A good tactic is one that your people enjoy.
7. A tactic that drags on too long becomes a drag.
8. Keep the pressure on.
9. The threat is usually more terrifying than the thing itself.
10. If you push a negative hard and deep enough it will break through into its counterside.
11. The price of a successful attack is a constructive alternative.
12. Pick the target, freeze it, personalize it, and polarize it.¹⁹⁰

C. The Corporate Campaign Comes to Organized Labor

The strategy of the American Federation of Labor-Congress of Industrial Organizations (AFL-CIO), the pre-eminent umbrella union in the United States, had traditionally been to maintain strength and influence through political campaign contributions and to grow and organize through union elections and strikes.¹⁹¹ This strategy shifted when John Sweeney, an early advocate and practitioner of the corporate campaign, was elected to the presidency of the AFL-CIO in 1995.¹⁹² This strategy shift accelerated with the recent split of the Change to Win Federation (CTW) from the AFL-CIO.¹⁹³ The CTW has largely abandoned traditional organizing and instead focuses its efforts on

¹⁸⁹ *Id.*

¹⁹⁰ *Id.* at 13; See also Saul Alinsky, RULES FOR RADICALS: A PRAGMATIC PRIMER FOR REALISTIC RADICALS 127-130 (1971).

¹⁹¹ See Manheim, *supra* note 165, at 29.

¹⁹² *Id.* at 38.

¹⁹³ Ivan Osorio, *Twenty-first Century Unionism?* COMPETITIVE ENTER. INST. (July 28, 2005), available at <http://www.cei.org/utills/printer.cfm?AID=4724>.

achieving card check and neutrality concessions from management through corporate campaigns.¹⁹⁴

The Service Employee International Union (SEIU) is one of the leaders of the CTW group of unions.¹⁹⁵ The SEIU, along with the American Federation of State County and Municipal Employees (AFSCME), targets, among other entities, hospitals and health care conglomerates.¹⁹⁶

With today's corporate campaign strategy against hospitals, the unions launch, through a variety of means, a series of highly-publicized attacks on target hospitals that are designed to embarrass the hospitals and to discredit the target hospitals in the minds of the public.¹⁹⁷ The goal of the corporate campaign: to coerce management into agreeing to neutrality, card check, and master agreements, at which point the union will call off the dogs.¹⁹⁸

Hospitals are logical targets for corporate campaigns.¹⁹⁹ There are nearly 7 million health care workers in the United States, and labor unions are desperate to penetrate this sector in an era when national work force unionization has been plummeting.²⁰⁰ Moreover, health care jobs of the types involved require personal contact between the employee and the patient—therefore the jobs cannot be exported and union leverage is enhanced.²⁰¹

To wage the corporate campaign, the union uses its allies in the news media, government, and among special interest groups—the stark union motives are thereby blunted and the campaign acquires an appearance of legitimacy through the involvement of these other entities.²⁰² The campaign involves economic, regulatory, legal, political and psychological warfare.²⁰³ The hospital's relationship with its community base is disrupted and the hospital's ability to conduct

¹⁹⁴ See *Under the Knife*, *supra* note 173.

¹⁹⁵ *Id.*

¹⁹⁶ See Haugh, *supra* note 5.

¹⁹⁷ Ivan G. Osorio, *The Service Employees International Union: Part 1: An Aggressive Union is Changing the Face of Organized Labor*, LABOR WATCH at 2 (June 2002), available at <http://www.capitalresearch.org/pubs/pdf/x3760042816.pdf>.

¹⁹⁸ Ryan Ellis, *Unions Use Smear Tactics in 'Corporate Campaigns'*, HUMAN EVENTS (April 23, 2007), available at <http://www.humanevents.com/article.php?id=20366>.

¹⁹⁹ See Haugh, *supra* note 5.

²⁰⁰ *Id.*

²⁰¹ *Id.*

²⁰² See Manheim, *supra* note 162, at 15.

²⁰³ *Id.* at 16.

business is impeded.²⁰⁴ The message to the hospital is “We unionize your workforce, or we destroy your reputation.”²⁰⁵

Often the complaint that the union presents to the public through the campaign is that a not-for-profit hospital is not doing enough charity work to justify its tax-exempt status.²⁰⁶ The hospital is often charged with harsh billing practices.²⁰⁷ Other issues that are exploited are patient safety and nurse-to-patient staffing ratios.²⁰⁸ The unions say that they simply wish to partner with hospitals to improve patient care and community service. Unionized hospitals, however, are not targeted for corporate campaigns. Furthermore, there is the clear understanding that the corporate campaign will cease when management accedes to neutrality and card check.

Union corporate campaigns against hospitals often involve the following tactics:²⁰⁹

- Newspaper, television and internet reports criticizing hospital charges, collection and billing practices.
- Demonstrations and picketing by special interest groups.
- Federal and state and local governmental investigations, regulatory audits, and efforts to pass punitive legislation that focus on allegations that a not-for-profit hospital is not doing enough charity care to justify its tax-exempt status—thereby jeopardizing the hospital’s tax-exempt status.
- Efforts are made to block hospital Certificate of Need applications, thereby jeopardizing hospital capital improvement projects.²¹⁰

²⁰⁴ *Id.* at 19.

²⁰⁵ See Osorio, *supra* note 197, at 2.

²⁰⁶ See Haugh, *supra* note 5.

²⁰⁷ *Id.*

²⁰⁸ *Id.*

²⁰⁹ See Stickler, *supra* note 10.

²¹⁰ Some states have legislation mandating state agency approval for certain health care capital improvement projects. A health care organization must file an application with this agency to obtain a “Certificate of Need” which authorizes the health care organization to proceed with construction. Interested individuals and organizations can petition the applicable agency to deny approval. See THE LEWIN GROUP, AN EVALUATION OF ILLINOIS’ CERTIFICATE OF NEED PROGRAM 7 (February

- Class action lawsuits and charges of unfair labor practices that involve inadequate hospital staffing policies and consequent patient injuries.
- Allegations of discriminatory pricing and that lower levels of capital investment in poorer neighborhoods is motivated by racism.

This paper will now illustrate how unions have employed some classic tactics in the course of recent corporate campaigns against health care entities.

C. The Case of Catholic Healthcare West

The following case illustrates the Saul Alinsky principles “make the enemy live up to their own book of rules” and “ridicule is man’s most potent weapon.”²¹¹ It also illustrates the modern union penchant for employing subversive allies from within the enemy’s camp as a potent weapon for undermining the enemy.

Catholic Healthcare West (CHW) is a chain of 48 hospitals in California, Arizona and Nevada.²¹² CHW is operated by the Sisters of Mercy and several other orders of Roman Catholic nuns.²¹³ The SEIU turned up the pressure on CHW in 1998 by charging that, by resisting unionizing efforts, the Sisters were not living up to their Catholic values.²¹⁴ The SEIU found a potent ally in this effort in none other than the National Conference of Catholic Bishops.²¹⁵

The SEIU charged at the assembly of the Catholic Health Association of the United States that Catholic doctrine requires a just workplace, and that it is not possible to have a just workplace without a union.²¹⁶ The SEIU challenged the nuns on how the Church can take a stand supporting unionization for farm workers but not for health care workers.²¹⁷

15, 2007), available at <http://www.ilga.gov/commission/cgfa2006/Upload/LewinGroupEvalCertOfNeed.pdf>.

²¹¹ See Alinsky, *supra* note 190, at 128.

²¹² See Manheim, *supra* note 165, at 76.

²¹³ CATHOLIC HEALTHCARE WEST, A LEGACY OF SERVICE, http://www.chwhealth.org/intradoc-cgi/idc.cgi_isapi.dll?IdcService=SS_GET_PAGE&nodeId=5005454 (last visited April 30, 2007).

²¹⁴ See Manheim, *supra* note 165, at 76.

²¹⁵ See Haugh, *supra* note 5.

²¹⁶ See Manheim, *supra* note 165, at 77.

²¹⁷ *Id.*

The SEIU carried the debate to full page ads in the *New York Times* and encouraged the faithful to engage Catholic Church officials in a “social justice dialogue.”²¹⁸ Articles appeared in the *National Catholic Reporter* illustrating quotes from Pope John Paul II supporting unionization.²¹⁹ The SEIU extended the dialogue to ads on several cable television systems alleging that the nuns were betraying their Catholic principles.²²⁰ In keeping with the religious theme, the SEIU organized its campaign around prayer vigils, candlelight rallies, pilgrimages, and church services.²²¹ They even conducted a rally when a Mother Superior visited a CHW facility.²²² On a more secular note, the SEIU also endeavored to channel managed care contracts away from CHW.²²³

The SEIU found potent allies within the Catholic Church to help hoist its banner. Monsignor George Higgins, a prominent advisor to the nation’s Bishops on labor matters, counseled the National Conference of Catholic Bishops that the nuns were out of line for hiring an anti-labor consulting firm.²²⁴ The Conference was persuaded.²²⁵

Sister Regina Williams, a prominent activist, accused CHW’s management of practicing “cafeteria Catholicism” in picking and choosing which Catholic principles they wish to uphold.²²⁶ Sister Mary Roch Rocklage, a CHW official, countered that “the Church does say that workers have a right to organize, it doesn’t say unions are the only way. There is a tendency to use sound bites from the Church’s teachings to beat up on us, saying we’re not following our own teachings.”²²⁷

Nevertheless, after a lengthy battle, CHW eventually signed a master bargaining contract with SEIU covering its hospitals in California and Nevada.²²⁸

²¹⁸ *Id.*

²¹⁹ *Id.*

²²⁰ *Id.*

²²¹ *Id.* at 78.

²²² *Id.*

²²³ *Id.*

²²⁴ See Haugh, *supra* note 5.

²²⁵ *Id.*

²²⁶ See Osorio, *supra* note 197, at 4.

²²⁷ *Id.*

²²⁸ See Haugh, *supra* note 5.

D. Confrontations in Chicago

Chicago has two major community hospital chains in the city and suburbs.²²⁹ Advocate Health Care has been targeted by SEIU.²³⁰ Resurrection Health, the largest Catholic health system in Chicago, has been targeted by the AFSCME.²³¹ The corporate campaigns against these two not-for-profit hospital chains have been ongoing for several years.²³²

Both unions are directing their attacks on the tax-exempt status of the hospitals by alleging that the hospitals are not providing adequate levels of charity care to the community and that the hospitals are engaging in harsh and punitive bill collecting practices.²³³ As we will see, both unions in Chicago employ the Saul Alinsky template that SEIU used successfully against Catholic Healthcare West and others.²³⁴

SEIU has established an excellent web site cataloguing its corporate campaign against Advocate Health Care.²³⁵ SEIU maintains the Hospital Accountability Project which has published myriad studies charging that Advocate Health Care uses predatory collection practices against the uninsured and does not do enough charity care to justify its tax-exempt status.²³⁶

The higher prices that the uninsured are charged—because they lack the insurance company negotiated discounts in exchange for volume that the insured enjoy—is characterized as “discriminatory pricing.”²³⁷

²²⁹ *Id.*

²³⁰ *Id.*

²³¹ *Id.*

²³² *Id.*

²³³ *Id.*

²³⁴ See Alinsky, *supra* note 190, at 127-130.

²³⁵ See Hospital Monitor, <http://www.hospitalmonitor.org>.

²³⁶ See *Frequently Asked Questions*, <http://www.hospitalmonitor.org/faq.htm> (last visited April 30, 2007); See also *Publications*, http://www.hospitalmonitor.org/resources_publications.htm (last visited April 30, 2007).

²³⁷ See *Discriminatory Pricing Facts*, http://www.seiu.org/health/hosp/dp_facts.cfm (last visited April 30, 2007); See also *Discriminatory Pricing Solutions*, http://www.seiu.org/health/hosp/dp_action.cfm (last visited April 30, 2007); See also SEIU HOSPITAL ACCOUNTABILITY PROJECT, UNINSURED AND OVERCHARGED: HOW ADVOCATE HEALTH CARE OVERCHARGES CHICAGO HOSPITAL PATIENTS (May 2003), available at http://www.seiu.org/docUploads/Discriminatory_Pricing_DP_Advocate.pdf.

SEIU has accused Advocate in multiple reports of “redlining,” meaning that it spends less on infrastructure and capital development in poor minority neighborhoods than it does in white affluent suburbs—a disparity motivated by racism.²³⁸ The SEIU apparently does not consider the fact that Advocate must compete with well-stocked suburban hospitals by maintaining comparable facilities in the suburbs as a valid explanation for the disparity.

SEIU picketed Advocate fundraisers and the homes of Advocate executives.²³⁹ Street theater is employed—hundreds of community and labor activists attempted to confront the Advocate CEO at a country club.²⁴⁰ In 2005 union operatives rounded up uninsured and homeless people and took them to emergency departments and instructed them to demand care.²⁴¹

Clergy, activists and an assembly of community groups are recruited to participate in street theater, to help embarrass Advocate, and to harass its executives.²⁴² The coalition urged the applicable state agency to deny Advocate’s application for a Certificate of Need to build a new hospital.²⁴³ Holy Scripture is invoked to indict Advocate, but because Resurrection Health Care has more of a religious identity, the weight of Christendom was brought to bear on Resurrection even harder as will be documented below.²⁴⁴

²³⁸ See Haugh, *supra* note 5; See also SEIU HOSPITAL ACCOUNTABILITY PROJECT, SEPARATE AND UNEQUAL (December 2004), available at <http://www.hospitalmonitor.org/pdf/seperate.pdf>.

²³⁹ See Haugh, *supra* note 5.

²⁴⁰ See *Hundreds Gather to Demand that Advocate Health Make Investments in Chicago Hospitals: Peaceful Demonstration Draws Sixteen Police Officers*, HOSP. MONITOR (Aug. 9, 2005), available at <http://www.hospitalmonitor.org/pdf/hundreds.pdf>

²⁴¹ See Haugh, *supra* note 5.

²⁴² See *Protocol Partners*, <http://www.hospitalmonitor.org/partners.htm> (last visited April 30, 2007); See also *Leaders Take Health Care Justice Issues to Advocate Headquarters*, HOSP. MONITOR, (July 28, 2005), available at http://www.hospitalmonitor.org/resources/leaders_take_healthcare.htm; See also *Leaders Sign “Protocol” for health care justice, seek meeting with governor: State’s largest health care provider a no-show at rally*, HOSP. MONITOR (July 24, 2005), available at http://www.hospitalmonitor.org/pdf/leaders_sign.pdf.

²⁴³ See *Patients and pastors speak against Advocate’s new hospital proposal*, HOSP. MONITOR (MARCH 11, 2004), available at <http://www.hospitalmonitor.org/principle2/2.htm>; See also THE LEWIN GROUP, *supra* note 210.

²⁴⁴ See *Scriptural Foundation of the Protocol for Agreement*, <http://www.hospitalmonitor.org/pdf/scripture.pdf> (last visited April 30, 2007); See also HOSPITAL MONITOR, *Faith in Action: Advocate Workers Call on Advocate to*

Healthcare Employees Acting at Resurrection Together (HEART), a group of Resurrection Health Care employees, is the AFSCME organizing committee for Resurrection.²⁴⁵ HEART, like SEIU, also maintains an excellent on-line chronicle of its corporate campaign exploits.²⁴⁶

A bond rating service allegedly felt that Resurrection's financial prospects would be improved by a "resolution" of the labor dispute—HEART may have taken the liberty of applying their own spin on the meaning of the word "resolution."²⁴⁷ HEART exhibits solidarity with major political figures—there are public pledges of support from state legislators as well as from U.S. Senators Obama and Durbin.²⁴⁸ AFSCME pressured a ballot vote in Evanston, Illinois to revoke the tax-exempt status of a Resurrection affiliate because of inadequate charity care—the measure failed.²⁴⁹ AFSCME also petitioned the Cook County Assessor and the Cook County Board of Review to revoke Resurrection's tax-exempt status—those petitions failed too.²⁵⁰ A street demonstration with community groups on Martin Luther King Jr. Day was organized to protest alleged racial discrimination against hospital employees.²⁵¹

Proclaim Jubilee by Respecting the UCC's and ELCA's Commitment to Employees' Freedom to form a Union, available at http://www.hospitalmonitor.org/pdf/faith_in_action.pdf.

²⁴⁵ See AFSCME COUNCIL 31, *Resurrection Nurse Helped Educate Congressional Candidates About Need for Labor Law Reform* (November 14, 2006), available at <http://www.afscme31.org/printable.asp?objectID=1064>.

²⁴⁶ See *Updates*, <http://www.reformresurrection.org/> (last visited April 30, 2007).

²⁴⁷ See *Bond Analysts: Working with Employees Could Improve RHC's Finances*, <http://www.reformresurrection.org/bond-analysts-working-with-employees-couldimprove-rhc-s-fin.html> (last visited April 30, 2007).

²⁴⁸ See *Nurses Meet with Key Legislators*, <http://www.reformresurrection.org/nurses-meet-with-key-legislators.html> (last visited April 30, 2007); See also *Large Crowd Gathers to Hear Obama, Others, Pledge Support for RHC Workers*, <http://www.reformresurrection.org/large-crowd-gathers-to-hear-obama-others-pledge-support-for-rhc-wo.html> (last visited April 30, 2007); See also *Building Momentum for 2007*, 3 THE HEART BEAT (Winter 2006), available at http://www.reformresurrection.org/images/stories/press/heartbeat_dec06.indd.pdf.

²⁴⁹ See Haugh, *supra* note 5.

²⁵⁰ See Jeremy Mullman, *Hospital's Tax Status Under Fire*, CRAIN'S CHICAGO BUS. (June 15, 2004), available at http://www.reformresurrection.org/images/stories/press/6_15_04_CRAIN_Tax%20Status%20Under%20Fire.pdf.

²⁵¹ See *King Day Event in Oak Park Highlights Discrimination Problems at West Suburban Hospital*, <http://www.reformresurrection.org/king-day-event-in-oak-park-highlights-discrimination-problems-at-west-suburban-hos.html> (last visited April 30, 2007).

HEART has met with state legislators to push for the enactment of hospital “safe staffing” legislation.²⁵² Alleged hospital OSHA violations are publicized by HEART.²⁵³ Multiple reports and formal studies by AFSCME allege poor quality health care at Resurrection.²⁵⁴

Resurrection Health Care, a Catholic institution, is suffering the bitter recriminations of its co-religionists, as did Catholic Healthcare West before it.²⁵⁵ Catholic and inter-faith religious leaders have been recruited to help HEART admonish Resurrection Health for violating its Catholic principles by resisting unionization. Dozens of prominent Catholic scholars and religious leaders have affixed their names in testament to Resurrection’s anti-union heresy.²⁵⁶

While the struggle in Chicago is ongoing, organized labor has met with astounding success in their corporate campaigns across the country. To date, the work forces of health care giants such as Kaiser Permanente, Tenet, HCA, Catholic Healthcare West, and New York

²⁵² See *Nurses Meet with Key Legislators*, <http://www.reformresurrection.org/nurses-meet-with-key-legislators.html> (last visited April 30, 2007); See also *Nurses Spur Action in House and Senate for Staffing Ratios*, <http://www.reformresurrection.org/nurses-spur-action-in-house-and-senate-for-staffing-ratios.html> (last visited April 30, 2007). Unions allege that patient safety issues are tied to hospital under-staffing of nursing personnel.

²⁵³ See *OSHA Cites St. Francis Hospital for Six Serious Violations*, <http://www.reformresurrection.org/osha-cites-st.-francis-hospital-for-six-serious-violations.html> (last visited April 30, 2007).

²⁵⁴ See *Get the Facts on the Quality of Care at Resurrection Hospitals*, <http://www.reformresurrection.org/get-the-facts-on-the-quality-of-care-at-resurrection-hospitals.html> (last visited April 30, 2007); See also AFACME COUNCIL 31, *Report Documents Deteriorating Quality of Care at Resurrection Hospitals: Nurses Speak Out* (November 10, 2005), available at <http://www.afscme31.org/printable.asp?objectID=930>; AFSCME COUNCIL 31, *The High Price of Growth at Resurrection Health Care: Corporatization and the Decline of Quality Care* (November 2005), available at http://www.afscme31.org/cmaextras/qualityof_care.pdf; AFSCME COUNCIL 31, *The Record on Resurrection Health Care: Hospital Quality 2007*, available at <http://www.reformresurrection.org/images/stories/resources/hospital%20quality%202007.pdf>; *Report Points to Quality of Care Deficiencies at Resurrection Hospitals*, PR NEWSWIRE, available at <http://www.reformresurrection.org/report-points-to-quality-of-care-deficiencies-at-resurrection-hosp.html> (last visited April 30, 2007).

²⁵⁵ See *Catholic Scholars Urge Resurrection Health Care to Respect Workers Rights*, <http://www.reformresurrection.org/catholic-scholars-urge-resurrection-health-care-to-respect-workers-r.html> (last visited April 30, 2007); See also *General Questions FAQ*, <http://www.reformresurrection.org/faq/cat.html> (last visited April 30, 2007).

²⁵⁶ See *An Open Letter in Support of Workers’ Rights at Resurrection Health Care*, http://www.reformresurrection.org/images/stories/press/ncr_ad.pdf (last visited April 30, 2007).

Hospital Association, among others, have been unionized through corporate campaigns.

E. Legal Challenges: Attorney General and the Trial Bar

Attorneys General around the country have been exerting various levels of pressure on tax-exempt hospitals over the charity care issue.²⁵⁷ Attorneys General in California, Ohio and Montana have been investigating the charity care records of tax-exempt hospitals.²⁵⁸ Attorneys General in Minnesota, New York, Kansas and Wisconsin are investigating pricing and collection practices of tax-exempt hospitals.²⁵⁹ The Minnesota Attorney General announced an agreement with all Minnesota hospitals regarding medical billing and debt collection standards.²⁶⁰

Among the more aggressive Attorneys General on the hospital charity care issue is Lisa Madigan of Illinois.²⁶¹ She has introduced legislation in the Illinois General Assembly requiring tax-exempt hospitals to, among other measures, spend 8% of their total operating costs on charity care.²⁶² The Madigan legislation has the support of

²⁵⁷ See Philip Mattera, *Uncharitable Charities: Non-Profit Hospitals are Under Fire for Mistreating the Uninsured*, CORP. RESEARCH E-LETTER NO. 61 (Sept.-Oct. 2006), <http://www.corp-research.org/archives/sep-oct06.htm>.

²⁵⁸ *Id.*

²⁵⁹ See Linda S. Moroney, *Tightening the Noose on Nonprofits? Nonprofits targeted for reform whether needed or not*, WIS. LAW JOURNAL, available at <https://www.drinkerbiddle.com/files/Publication/5325bccb-87fd-4ce1-8762-0702f4ed-b306/Presentation/PublicationAttachment/174a4666-039b-4d97-a26c-0326e7cf3f83/TighteningTheNooseOnNonprofits.pdf> (last visited April 30, 2007); See also Kathleen Day, *Hospital Charity Care is Probed*, WASH. POST, Sept. 13, 2006, at D2, available at <http://www.washingtonpost.com/wp-dyn/content/article/2006/09/12/AR2006091201409.html>.

²⁶⁰ See Attorney General Lori Swanson and Minnesota Hospitals Announce Continuation of Fair Medical Billing Agreement (April 4, 2007), <http://www.ag.state.mn.us/Consumer/PressRelease/FairMedicalBilling.asp>; See also Minnesota Attorney general Blasts Hospital for Failures in Charity Care, Governance, DON KRAMER'S NONPROFIT ISSUES (March 2005), available at <http://www.nonprofitissues.com/public/features/leadfree/2005mar1-IS.html>.

²⁶¹ See OFFICE OF THE ILLINOIS ATTORNEY GENERAL, *Madigan Proposes Two Bills to Hold Hospitals Accountable for Charity Care, Stop Unfair Billing and Collection Practices* (January 23, 2006), available at http://www.illinoisattorneygeneral.gov/pressroom/2006_01/20060123.html.

²⁶² *Id.*; See also Illinois Attorney General 2006 Legislative Agenda, available at <http://www.ilga.gov/legislation/94/HB/PDF/09400HB5000lv.pdf>

SEIU and AFSCME.²⁶³ In 2006, Lisa Madigan's election campaign received significant monetary support from organized labor.²⁶⁴

Incidentally, all of this commotion did not fail to attract the attention of the trial bar. Attorney Richard Scruggs, among others, have filed multiple class action lawsuits against hundreds of charity hospitals alleging that they charge the uninsured inflated prices, that they use abusive collection tactics, and that they provide inadequate levels of charity care.²⁶⁵

VI. CONCLUSION

Tax-exempt hospitals in the United States are in a precarious position. They face threats and challenges from many quarters as they struggle to fulfill their mission to provide quality healthcare to the general population. Tax-exempt hospitals are for the most part struggling financially as they strain to serve under-insured populations in an environment of sharp reductions in reimbursements from both government and private payers.

Because of their fragile financial state, very few tax-exempt hospitals would be able to function adequately or even at all without their tax exemptions. As was illustrated above, however, their tax exemptions are under attack from political, governmental and social entities—entities that are instigated and motivated by cunning and malicious labor unions. The labor unions cynically exploit the charity care issue to serve their own ends—the unionization of the hospital's

²⁶³ See OFFICE OF THE ILLINOIS ATTORNEY GENERAL, *supra* note 261.

²⁶⁴ With the data 75% complete, 55.4% of Lisa Madigan's 2006 campaign contributions came from organized labor—5.03% (\$102,500) from SEIU and 2.45% (\$50,000) from AFSCME. See FOLLOW THE MONEY, *Candidate Summary, Lisa Madigan*, available at <http://www.followthemoney.org/database/StateGlance/candidate.phtml?si=200614&c=417323> (last visited April 30, 2007).

²⁶⁵ See Daren Fonda, *Sick of Hospitals*, TIME, Sept. 27, 2004, at 48, available at <http://www.time.com/time/printout/0,8816,699425,00.html>; See also Julie Appleby, *Hospital Suits Fall Flat, but Debate Rages*, USA TODAY, Apr. 25, 2005, at 4B, available at http://www.usatoday.com/money/industries/health/2005-04-24-hospital_x.htm; See also *Uninsured Expand Class Action Claims for Charity Care Against Nonprofit Hospitals*, DON KRAMER'S NONPROFIT ISSUES (August 2004), available at <http://www.nonprofitissues.com/public/features/leadfree/2004aug1-IS.html>; See also *First Two Class Action Lawsuits in Northwest by Uninsured Patients Against Nonprofit Hospital Systems and Hospitals Filed in Federal Courts in the States of Oregon and Washington: 49 Such Litigations Now Underway Around the Country Covering Approximately 370 Hospitals* (Sept. 29, 2004), available at <http://www.ohac.org/pdf/Lawsuit%20PR.pdf>.

workforce—a matter which ultimately has no bearing on the charity care issue.

Moreover, the tax exemptions of the hospitals are vulnerable to attack because of the dysfunctional and unrealistic legal requirements that hospitals must satisfy in order to qualify for the tax exemptions. Among the worst of many bad rules, as discussed above, is that the courts have declared that un-reimbursed care is charity care only when a decision is made to not bill the patient before care is rendered—bad debt expense cannot qualify as charity care.

This rule does not make sense because the vast majority of bad debt expenses constitute a hospital's permanent and predictable burden to serve indigents people who are unable to pay. The prospect of conducting a financial analysis to verify that indigent patients deserve charity care before the care is rendered is unrealistic. Moreover, hospitals cannot be required to automatically forgive debt without making diligent collection efforts, because such a practice will naturally result in less incentive for the general population to purchase health insurance, and as a consequence more people will be uninsured.

Some judicial opinions on the criteria for tax exemption are simply shocking. The concept that a not-for-profit hospital may not make profits and that a substantial portion of the modern tax-exempt hospital's revenues must come from donations betray a startling disconnect from reality.

The exclusive use criteria make tax-exempt hospital contracts with private entities risky because such transactions potentially jeopardize the hospital's tax-exempt status. This rule needs to be liberalized to allow tax-exempt hospitals to engage in efficient, cost saving, and quality enhancing market based activity.

Also, the courts and the legislatures have not even defined how much charity care is necessary to qualify for tax exemption. This issue may even be moot since the government has regulated the health care system so much and has placed so many structural burdens on the health care system that taxing hospitals as if they were free market entities may not make sense. As the financial analysis suggested, the tax-exempt hospital system would most likely be devastated if the tax exemptions were revoked—and the result would be massive social hardship from the loss of the many societal benefits that tax-exempt hospitals provide.

All of these problems are then compounded by the cynical exploitation of the charity care issue by labor unions. Labor unions use the dysfunctional charity care rules to their advantage—since proper

criteria for the charity care exemptions are so ill-defined and poorly-conceived, tax-exempt hospitals become vulnerable to attack. The result is more risk, more cost, more distractions and more burdens on the already over-stressed hospital industry.

It is time for the state legislatures to engineer coherent and economically-sound tax exemption rules that hospitals can realistically comply with. It is also time for labor unions to stop exploiting the current dysfunctional tax exemption laws in their unjust, vicious and self-serving corporate campaigns against the nation's tax-exempt hospitals—corporate campaigns that severely undermine struggling safety net hospitals and thereby threaten health care access for the most vulnerable members of society.